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## EMT-P BASIC SCOPE PROCEDURES

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### I. EXTERNAL JUGULAR VEIN ACCESS

#### FIELD ASSESSMENT/TREATMENT INDICATORS

Patient condition requires IV access and other peripheral IV access attempts are unsuccessful.  
Patient older than 15 years of age, Base Hospital contact not required  
Patient 9 to 15 years of age, Base Hospital order required  
Patient 1 day to 8 years of age, not indicated

#### PROCEDURE

1. Inform patient of procedure, if alert.
2. Utilize axial spinal immobilization in trauma patients. If not in axial-spinal immobilization extend and stabilize patient's neck. Maintain axial stabilization if the need to remove C collar arises.
3. Place in trendelenberg position, or apply slight pressure at base of vein for tourniquet effect
4. Obtain external jugular vein access with syringe attached.
5. Securely tape catheter with occlusive dressing in place and continue to monitor for patency
6. Recheck site frequently for signs and symptoms of infiltration

### II. EMERGENCY SYNCHRONIZED CARDIOVERSION

#### FIELD ASSESSMENT/TREATMENT INDICATORS

Symptomatic Ventricular Tachycardia with pulses  
Symptomatic Supraventricular Tachycardia  
Patient older than 15 years of age, Base Hospital contact not required  
Patient 9 to 15 years of age, Base Hospital order required  
Patient 1 day to 8 years of age, not indicated

#### PROCEDURE

1. Monitor patient in a lead that maximizes upright R wave and minimizes T wave, and observe location of synchronized marker on the R wave.
2. Midazolam 1-2 mg slow IV push may be given to all awake patients.
3. Morphine Sulfate 1-2mg slow IV push when BP > 90mmHg.
4. Select energy level setting, 100 joules, or a clinically equivalent biphasic energy level per manufacture guidelines.
5. Procedure may be repeated at 200, 300 & 360 joules, or a clinically equivalent biphasic energy level per manufacture guidelines.
6. If cardioversion is successful, continue to monitor and refer to corresponding protocol.
7. Repeated cardioversion attempts at 360 joules, or a clinically equivalent biphasic energy level per manufacture guidelines, may be ordered with Base Hospital contact or in radio communication failure.
8. If ventricular fibrillation should occur during preparation or following cardioversion, immediately:
  - a. Turn off synchronizer and check pulse
  - b. Charge unit to 200 - 360 joules, or a clinically equivalent biphasic energy level per manufacture guidelines.
  - c. Defibrillate per corresponding protocol
9. Contact Base Hospital for further medication orders.
10. Document all reassessments of rhythm and pulses.

### **III. NEEDLE THORACOSTOMY**

#### **FIELD ASSESSMENT/TREATMENT INDICATORS**

Evidence of chest trauma

Hypotension

Shock syndrome (e.g. alterations in skin signs, vital signs and/or mental status)

Progressively worsening dyspnea/cyanosis

Decreased or diminished breath sounds on the affected side

Distended neck veins

Tracheal deviation away from the affected side

#### **PROCEDURE**

1. Explain procedure to patient:
  - a. If conscious, place patient in upright position if tolerated
  - b. If patient is unconscious or in axial-spinal immobilization, leave supine
2. Select a 14 or 16 gauge 2 to 2 ½ inch needle and cannula with syringe attached. For patients less than 50kg, use 18g, 1 to 1 ¼ inch needle and cannula. Or use approved pre-packaged device.
3. Prepare area with antiseptic wipes - second intercostal space, midclavicular line.
4. Insert needle perpendicular to the chest wall, at the level of the superior border of the third rib until pleura is penetrated as indicated by one or more of the following:
  - a. A rush of air
  - b. Ability to aspirate free air into the syringe
5. Remove syringe and needle stylet and leave cannula in place. Add flutter valve.
6. Secure needle hub in place with tape or other approved device.
7. Reassess patient lung sounds and respiratory status immediately and every five minutes.
8. Contact Base Hospital once procedure is completed with vital signs and respiratory status.

### **IV. VAGAL MANEUVERS**

#### **FIELD ASSESSMENT/TREATMENT INDICATORS**

Supraventricular Tachycardia, or Atrial fibrillation/flutter with rapid ventricular response and

Minimal or no symptoms which indicate poor perfusion (dyspnea, chest pain, or alteration in hemodynamic status)

#### **RELATIVE CONTRAINDICATIONS**

Extreme hypertension

Suspected acute MI

Suspected elevated ICP

#### **PROCEDURE**

1. Explain procedure to patient
2. Have patient perform one of the following procedures:
  - a. Have the patient pinch his nostrils together, close mouth and blow against a closed glottis
  - b. Have patient bear down as if having a bowel movement
  - c. Have patient submerge face in ice water or apply cold wet washcloth against face (preferred method for infants)
3. All procedures should be performed until arrhythmia is terminated or for a maximum of 10 seconds
4. Re-evaluate cardiac and hemodynamic status. Document rhythm before, during and after procedure
5. If rhythm does not convert within 10 seconds, follow Protocol Reference #6004

## **V. TRACHEAL INSTILLATION OF MEDICATIONS**

### **FIELD ASSESSMENT/TREATMENT INDICATORS**

No peripheral vascular access readily available  
ET, NT, or needle cricothyrotomy device in place

### **RECOMMENDED MEDICATIONS**

1. Lidocaine
2. Epinephrine
3. Atropine
4. Naloxone

### **PROCEDURE:**

1. Assure and maintain airway placement
2. Pre-oxygenate 15-30 seconds with 100% O<sub>2</sub> via BVM
3. Discontinue CPR
4. Instill medications
  - a. Patient 9 years of age and older - double the IV dose
  - b. Patient 8 years of age and younger - single the IV dose for all medications except Epinephrine which should be given at 0.1 mg/kg (1:1000) with total fluid volume not to exceed 2-5cc (medications + NS)
5. Re-oxygenate 15-30 seconds with 100% O<sub>2</sub>.
6. Resume CPR
7. Re-evaluate airway placement and response to therapy